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ABSTRACT

The homeless mentally ill, numbering approximately 300,000 persons, are a group neglected and forgotten by society. While deinstitutionalization promised a bright future, the necessary, long-term support to implement deinstitutionalization never materialized. Government policies have helped produce problems that encourage recidivism and homelessness. A model of an integrated and comprehensive system of general and specialized services for the mentally ill includes outreach; assistance for basic needs; adequate mental health care; crisis assistance; comprehensive psychosocial services; rehabilitative and supportive housing options; back-up support, assistance, consultation, and education; recognition and involvement of natural support systems; establishment of grievance procedures and mechanisms to protect client rights; and facilitation of the use by clients of formal and informal helping systems. The success of a program based on this model requires leadership, improved financing, and better coordination among service providers. Without facing squarely the task of providing adequate services for individuals with mental illness living in the community, states can expect continued problems with homelessness. Policymakers and providers should focus on improving community mental health and rehabilitation systems and improving the emergency and transitional shelter network for the homeless mentally ill. (Specific programmatic and legislative responses of the states are included.) (ABL)

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MENTAL HEALTH PROJECT

Human Services Series

The Homeless Mentally Ill: No Longer Out of Sight and Out of Mind

by

Rebecca Craig and Andrea Paterson

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THE HOMELESS MENTALLY ILL: NO LONGER OUT OF SIGHT AND OUT OF MIND

INTRODUCTION

They're a familiar sight on many downtown street corners: challenging the voices only they hear, demanding answers from passersby. Since the early 1960s, the increasing presence of individuals with mental illness among our nation's homeless has substantially changed the face of this troubled population. Bewildered by the noise and confusion of the city, they huddle over grates, trying to protect their bodies against the frigid cold. They wait in lines for a hot meal or a place to spend the night. They rattle up and down back alleys, riffling through dumpsters, sleeping in cardboard lean-tos. In the shelters, homeless people who are mentally ill are preyed upon by the stronger members of the homeless population. They are a group neglected and forgotten by society. Nationwide, according to the National Coalition for the Homeless, roughly 300,000 persons with serious mental illness are homeless (1, p. 1). The reasons behind their presence on the streets are complex, their future uncertain.

OVERVIEW: THE VISION AND THE REALITY OF DEINSTITUTIONALIZATION

Primary Causes for Homelessness: The Lack of Commitment to Deinstitutionalization. Although the numbers vary, between 25 to 50 percent of the nation's homeless are mentally ill (2, p. 88). Between 20 to 40 percent of the nation's homeless men and between 50 to 85 percent of the homeless women are seriously mentally ill (1, p. 7). One study indicates that of the nation's total population suffering from mental illness, roughly 15 percent are homeless (1, p. 5). The study further reports that, once homeless, only 15 to 30 percent will receive any kind of mental health assistance (1, p. 6). In human terms, the meaning of these percentages is evident on the streets of America's cities; in public policy terms, the percentages demand reconsideration of a sound idea--the deinstitutionalization of persons with mental illness--gone astray.

Prior to the deinstitutionalization movement of the 1960s and the 1970s, persons with serious mental illness had been largely warehoused in state hospitals. Deinstitutionalization seemed to promise a brighter future. New psychoactive drugs protected those in crisis against one-way tickets to the state hospital. Community-based treatment promised greater civil liberties and individualized care for persons with mental illness and greater financial freedom for the states, burdened with supporting their overflowing state hospitals.

While deinstitutionalization promised a bright future, few disputed that the movement would have to be supported both by dollars and by an ongoing public policy commitment. Many mental health professionals, consumers, and advocates claim that this necessary, long-term support never materialized. The policies to implement deinstitutionalization were a far cry from the dream.

First of all, states lacked financial commitment to the deinstitutionalization of individuals with mental illness. Dollars that could have followed patients out of the state hospitals and into the community generally did not follow. Even after many of their residents were gone, the state hospitals continued to place considerable demands on the financial resources of the state mental health systems. New state funds specifically targeting community-based treatment programs were slow to come. In many states, state hospital resources were reduced without an accompanying increase in funding for community programs.

Second, the open, loosely structured settings of the community treatment system were frequently not appropriate to the treatment needs of individuals with mental illness, who often deal poorly with stress, have trouble negotiating service bureaucracies, and are frequently isolated from and suspicious of systems that have consistently failed to address their problems.

Left to fend for themselves in the community, the deinstitutionalized individuals were often unable to piece together a treatment program, even when the necessary services existed. Community service providers often misinterpreted this inability as a lack of motivation or an ambivalence toward services, and began to pass over individuals who were severely mentally ill in favor of populations seemingly more willing and receptive to treatment.

Finally, states did not act to ensure an appropriate range of residential treatment alternatives. Of the nearly half-million patients released during deinstitutionalization, many simply ended up back with their families. In some communities, as many as one-third ended up in minimum-service facilities such as board-and-care homes (2, p. 63); others were forced to make do in single-room-occupancy (SRO) hotels and nursing homes, which offered, at best, custodial care, when more extensive support services were needed.

In short, the policies and practices of federal and state deinstitutionalization efforts, as well as federal, state, and local housing policies, have helped produce a tangle of interlocking problems that often work together to encourage recidivism and homelessness.

- Criminalization. Because individuals who are homeless and mentally ill can be extremely disruptive and a public "eye sore," many communities have begun to insist that something be done to get them off the streets. Yet the lack of community-based housing and support services often has left the job of caring for and treating these individuals to local jails. Estimates put the number of county jail residents sharing a common history of homelessness as high as 34 percent (2, p. 68).

- The Revolving Door/Recidivism. The lack of community-based services has created a sub-group of individuals with mental illness who shuttle back and forth between the hospital and the community. Unable to gain access to the services that could help them lead more stable lives, the homeless individuals who are mentally ill are particularly inclined to be caught in this "revolving door." A recent study of admissions to a San Francisco general hospital's emergency psychiatric unit indicated that 30 percent of the patients admitted were homeless (2, p. 94).

- Inadequate Living Arrangements and Support Services. Within the communities, the range of residential programs necessary to keep persons with mental illness off the streets simply does not exist. Board and care facilities and SRO hotels often mean the difference between an immediate home and homelessness. However, these facilities lack the support programs and the supervision necessary to avert the future homelessness of persons with mental illness in crisis.

- A New Category of Young Chronic Patients. Deinstitutionalization's checkered 20-year history has helped spawn a generation of young chronic patients who have, at most, been briefly hospitalized or have received only marginal care and assistance in coping with their illness. The high incidence of homelessness among this group has significantly lowered the average age of individuals who are mentally ill and homeless.

Additional Causes of Homelessness: 20 Years of Social Services and Housing Strife. Many additional factors have contributed to homelessness among individuals with serious mental illness. The general erosion of mental health and social services on both state and federal levels has increased competition for existing services, already inaccessible to many homeless individuals with mental illness. Federal dollars going to state block grants for community mental health services have been reduced. Changes in federal and state aid policies that have traditionally affected the underprivileged ill have also encouraged homelessness among persons with mental illness.

In addition, the eligibility requirements for Social Security Disability Insurance are time-consuming and complicated. Applications for Supplemental Security Income, for example,

can require eight to 24 months for a determination, with 80 percent of the applicants initially turned down (3, p. 6).

Moreover, the inadequate housing market available to individuals with mental illness has been further depleted. Rent increases, the destruction of housing, the increased demand for public housing, the elimination of many public housing programs and the preference extended to other disabled populations over persons with mental illness have all contributed to the problem.

- In the past 10 years, median rent has increased at a rate significantly greater than the average income. California's average rent rose from $113 a month to $253 between 1970 to 1980 (3, p. 3). New York rents more than doubled between 1975 and 1984 (6, p. 12).

- Over a million SRO hotels, nearly half the total stock, were destroyed between 1970 and 1982. An estimated 33 percent of the hotel rooms were rented to persons with serious mental illness (1, p. 4).

- Federal Section 8 housing subsidies and public housing program funds have gone from $26.7 billion in 1980 to $8.6 billion in 1983. In 1983, no funds were allocated for construction of new public housing, as compared to $3.7 billion in 1980 (3, p. 4).

- Board and care facilities find it makes better financial sense to serve other disabled populations over persons with serious mental illness. For a developmentally disabled client, a board/care facility would receive $525 to $840, whereas a flat rate of $476 would be offered for a person with mental illness (2, p. 64).

Recognizing the severity of the problem, the federal government has moved to improve housing and care for the homeless with the passage of the Stewart B. McKinney Homeless Act of 1987 (P.L. 100-77). The legislation authorizes slightly more than $1 billion to provide both emergency and long-term approaches to housing, including the integration of mental health services, temporary housing programs with supportive services, primary health services, and demonstration projects to test new approaches for community-based mental health services. However, much work is still left to be done by state legislators, who must fashion legislation to meet the specialized needs of homeless people in their states.

GENERAL LEGISLATIVE GUIDELINES

Homeless people who suffer from mental illness are a fundamentally different group from the homeless who are not troubled by a mental illness. They also differ from individuals who are seriously mentally ill and have homes and who are involved in treatment programs in that they tend to be more isolated from friends and family and to reject the structure of most mental health programs.

This uniquely troubled population requires a carefully integrated and comprehensive system of both general and specialized services. Anne Lezak, Coordinator of the Program for the Homeless Mentally Ill, National Institute of Mental Health (NIMH), presents a comprehensive model to address the problems of homeless individuals with mental illness. The model is based on NIMH's Community Support Program (5).

Outreach. Outreach efforts suited to the target population are necessary to locate and identify homeless clients with psychiatric disabilities and to link them to potential services. Outreach staff could go into alleys, shelters and soup kitchens, build a relationship with the potential client by approaching him or her in a non-threatening way--offering coffee or sandwiches--over a period of months, and offer to help the client link up to other available resources. New York City's Project Help finds homeless persons who are mentally ill by

cruising the city in a mobile outreach unit and by taking referrals from a hotline. Project Help provides its clients with crisis medical and psychiatric services.

Assistance in meeting basic needs. Many argue that basic needs for food, shelter and clothing must be met before any other treatment needs of the homeless individuals with mental illness are considered. Few homeless people will ask for assistance in meeting basic needs. To overcome this reticence, a non-threatening environment will generally produce the best results such as a downtown "drop-in center," where few questions are asked in return for a meal, a good night's sleep, or a hot shower. The outreach worker who has gained the homeless individual's trust is an ideal person to offer assistance in meeting basic needs.

Adequate mental health care. Many homeless individuals with mental illness shun the formal mental health system. Mental health service providers dealing with homeless individuals may do best to provide initial mental health services in shelters or soup kitchens. Services can also be provided in conjunction with mobile outreach programs, or in non-threatening settings such as "community living rooms," which offer a comfortable place to relax as well as a link to the maze of formal services. Los Angeles' Downtown Women's Center provides homeless women with meals, a place to go during the day, and psychiatric and medication services.

Twenty-four hour crisis assistance. Homeless people with psychiatric disabilities may require crisis assistance in places like shelters or soup kitchens, which generally lack mental health professionals. To alleviate this problem, such professionals can help the para-professionals and volunteers working in these places by providing crisis intervention training. Mental health professionals can also work with criminal justice professionals to develop appropriate alternatives for the person in crisis and to develop mechanisms for brief psychiatric hospitalization.

Comprehensive psychosocial services. In conjunction with having their basic needs met, homeless individuals with mental illness can also benefit from basic vocational rehabilitation services, case management, residential services and socialization programs. Once these initial services have been provided, the client may be drawn into a more long-term psycho-social rehabilitation program that provides training in the living, vocational and social skills that are essential to the success of future residential placements.

A range of rehabilitative and supportive housing options. Individuals with serious mental illness require a range of living arrangements with varying degrees of supervision and structure. In addition to providing an adequate range of living arrangements, a community support system specifically targeting homeless individuals with mental illness would need to provide for emergency shelters, as an immediate alternative to life on the streets and, perhaps more important, for transitional housing as an opportunity to plan for more long-range treatment and rehabilitation efforts. The Buckelew Housing Program in San Rafael, California, provides an array of housing opportunities--from the highly structured and supervised program, to the largely independent apartment--to help bridge the gap between the hospital and the community.

Back-up support, assistance, consultation and education. Because homeless persons with psychiatric disabilities suffer the dual stigma of mental illness and homelessness, they become targets for discrimination and ostracism. Those involved in a community support system or in other advocacy groups could act as advocates and assistants for all who come in contact with the homeless individuals with mental illness--landlords, employers, social support workers, families--to help them understand this complex population. The Los Angeles Skid Row Development Corporation combines outreach to and involvement in the local business community with the Corporation's efforts to meet the housing and employment needs of the homeless individuals in the Skid Row area.

Recognition and involvement of natural support systems. Churches, local businesses, neighborhood organizations and voluntary agencies are already working to combat homelessness.

A community support system for homeless individuals with psychiatric disabilities should involve natural support programs for individuals with mental illness. The COMPEER program, for example, in Rochester, New York, matches individuals suffering from mental illness with community volunteers who assist in many of the functions of case management.

Establishment of grievance procedures and mechanisms to protect client rights. Homeless people suffering from mental illness may act in unusual, highly-visible ways. This, combined with a general bias against mental illness, makes this troubled population much more susceptible to criminalization, hospitalization, and both overt and covert discrimination. Support systems staff and other community advocates could work to establish grievance procedures under which the rights of the homeless individuals with mental illness could be ensured: the right to shelter; the right to entitlements; the right to treatment, etc.

Facilitation of the use by clients of formal and informal helping systems. Very often, homeless persons with mental illness need help in identifying and accessing housing and support services. Ideally, one person should be appointed to assist the homeless person through the maze of helping systems. Los Angeles' Mental Health Skid Row Project patches together mental health services for use in shelters. The Project uses a team approach with other agencies, enabling them to offer food, shelter, clothing, and medical and psychiatric care in a coordinated fashion.

The American Psychiatric Association (APA), in its task force report on homeless individuals with mental illness, maintains that states can also focus their attention in several additional areas, if they wish to stem the growing tide of homelessness among persons with mental illness:

- Fund additional research into the causes of mental illness and homelessness;
- Ensure a coordinated effort among service providers that spares individuals who are homeless and mentally ill the task of negotiating different service bureaucracies;
- Spend additional money for the development of long-term solutions to the problems of homelessness among persons with serious mental illness; and
- Reserve some part of the former state hospital system for the ongoing institutional care of that small percentage of the individuals with mental illness who, unable to care for themselves even with adequate residential options and community support services, often end up on the streets.

OVERCOMING THE ROADBLOCKS TO A COMMUNITY SUPPORT SYSTEM FOR THE HOMELESS MENTALLY ILL

The implementation of a Community Support Program (CSP) model for homeless persons with mental illness may promise a brighter future for this often-neglected population. However, the extent of the programs in each state will depend on the size of the homeless population, the amount of public support, and the resources each state has to devote to the problem. Certain ingredients are necessary to ensure the success of programs for homeless individuals with mental illness, particularly the Community Support Program model (5).

Leadership. Many service providers will have to contribute to the effort of getting homeless persons with mental illness off the streets. Mental health professionals will need to demonstrate leadership that will serve to inspire other human service workers. On a program level, mental health professionals can identify, document and evaluate the success of innovative program models that deal with the homeless persons with mental illness and share the results of such program successes with others working with the population. On a research level,

professionals can continue to explore the causes of homelessness so that service providers can anticipate emerging service needs.

Improved financing. The community support program approach requires a broad financial base combining traditional mental health and disability insurance with innovative financing mechanisms. The traditional Social Security disability programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), can be critical to the disabled person trying to find and maintain adequate housing. To ensure that these disability programs support homeless individuals with mental illness, states could work with necessary federal and state officials to achieve the following goals:

- Develop special outreach programs for getting the homeless enrolled in such benefit programs;

- Adopt standards for quick determinations, including presumptive disability assessment to obtain income maintenance for obviously disabled homeless individuals as soon as possible; and

- Develop procedures for maintaining housing payments for SSI/SSDI recipients who are briefly hospitalized, as a way to prevent homelessness.

Medicare and Medicaid also play key financing roles. Mental health care under Medicare is largely limited to inpatient care and partial reimbursement for non-hospital services. Under Medicaid, neither standard nor state optional benefits typically cover the case management, adult day treatment and psychosocial rehabilitative services required by a person with serious mental illness. However, under the "Home and Community-Based 2176 Waiver's Program," a state can obtain a waiver for Medicaid benefit restrictions if it can demonstrate "budget neutrality," i.e., it can provide a mix of alternative services for no more total dollars than those spent on traditional services. Such a waiver could provide flexibility to reimburse services provided through a community support program for homeless persons with mental illness.

Another key element in the financing of a CSP involves the transfer to community-based programs of the funds spent on the state hospitals. A state must provide adequate community-based mental health and psycho-social rehabilitation services if it hopes to prevent homelessness among the individuals who are mentally ill.

Better coordination among service providers. At present, responsibility for the services that might begin to address the problems of the homeless individuals with mental illness is scattered among various health, housing, and human service agencies, creating service discontinuities and funding gaps. Mental health professionals must begin aligning themselves with other professionals to ensure a united voice in obtaining more affordable housing and adequate support services within the reach of the state's disabled populations.

THE STATES' RESPONSE IN RECENT YEARS

A few states have attempted to address comprehensively the needs of individuals who are homeless and mentally ill. In general, however, state legislation addresses a discrete problem that feeds into the larger problem of homelessness, such as the lack of affordable housing and support services for persons with psychiatric disabilities living in the community.

Comprehensive Service Efforts. At least two states--California and New York--have attempted to address the needs of the homeless mentally ill in a comprehensive fashion. New York has attempted to combat homelessness among the mentally ill by passing various interlocking pieces of legislation over the last decade. New York began by providing local governments with 100 percent state reimbursement of the net operating costs for services to persons who had been patients in a state psychiatric facility for five years or more, and who

were consequently released (1974 N.Y. Laws, Chap. 620), and for public assistance and care, such as AFDC and home relief, provided to discharged state hospital residents (1974 N.Y. Laws, Chap. 621). The state subsequently provided full reimbursement for medical assistance provided to individuals eligible for such assistance because of a mental disorder (1983 N.Y. Laws, Chap. 816).

In 1984, the Legislature authorized the commissioner of mental health to establish a continuum of community residential services for persons with mental illness through state aid to local governments and voluntary agencies for up to 100 percent of the operating costs and up to 50 percent of the capital costs of such residences (1984 N.Y. Laws, Chap. 298). In 1985, the Legislature authorized a third state-approved residential program for individuals with mental illness, also eligible for 100 percent reimbursement: a "residential care center for adults," targeted at those homeless mentally ill who cannot handle the stress of more structured programs but who need more than a place to stay (1985 N.Y. Laws, Chap. 351). In 1983, New York also created the Homeless Housing and Assistance Program, establishing separate funds for housing assistance to the homeless and for shelter facilities for homeless individuals (1983 N.Y. Laws, Chap. 61). A 1986 measure (1986 N.Y. Laws, Chap. 746) consolidated two major assistance programs for mental health services into a new 100 percent state funded community support services program to finance services to persons with severe mental disabilities including mentally ill homeless or those residing in shelters for the homeless.

Housing and Support Services. While not exhaustive, the following state examples illustrate approaches to the problems of housing and support services for the homeless mentally ill.

California (1987 Cal. Stats., Chap. 116) allows the state and counties to use their vacant and under-utilized public facilities as emergency housing for the homeless.

Connecticut (1987 Conn. Acts, P.A. 309) added emergency shelters and mobile homes to the types of projects the Department of Housing may fund under its program for homeless persons.

Louisiana (1987 La. Acts, P.A. 505) will provide state money to match local and federal money to encourage local efforts to construct and rehabilitate housing for the homeless.

New Jersey enacted the Prevention of Homelessness Act (1984 N.J. Laws, Chap. 180) to provide temporary rental or other housing assistance to persons who are homeless or in imminent danger of homelessness, to authorize special subsidies and loans to assist in the establishment of low income housing, and to provide medical support services for homeless individuals.

New York (1987 N.Y. Laws, Chap. 790) now allows municipalities to make loans to certain non-profit housing development fund companies to build or rehabilitate permanent housing for the homeless.

Maryland established special shelter programs for homeless women (1980 Md. Laws, Chap. 851 and 1985 Md. Laws, Chap. 151). Maryland also established (1984 Md. Laws, Chap. 777) a "shelter, nutrition, and service program for homeless individuals" to provide crisis and transition shelter, proper nutrition, and basic services to homeless individuals. Under the Rental Allowance Pilot Program established in 1986, Maryland allows rental allowance payments to be made to, or on behalf of, homeless persons (1987 Md. Laws, Chap. 226).

Pennsylvania (1985 Pa. Laws, Act 57A) appropriated funds for the creation of short-term housing facilities and the establishment of low-cost single room occupancy housing facilities.

Massachusetts (1983 Mass. Acts, Chap. 450) enacted the "Homelessness Act" which removed address requirements for general relief applicants and required the Department of Mental Health to coordinate services for the homeless through several departments.

General efforts to provide adequate community-based housing for persons with mental illness also help the homeless mentally ill.

- Arizona (1986 Ariz. Sess. Laws, Chap. 398) provides services through pilot projects to persons with serious mental illness with outreach efforts directed at homeless shelters, including: short-term crisis beds, community residential services; case management, transportation, and outreach.

- Hawaii provided guidelines for a statewide system of residential treatment programs, that will provide a range of alternatives to institutional care (1980 Hawaii Laws, Act 211 and 1985 Hawaii Laws, Act 219). In 1986, Hawaii added a new type of service to the residential continuum with an unsupervised, independent living arrangement (1986 Hawaii Sess. Laws, Act 237).

- Illinois (1985 Ill. Laws., P.A. 84-366) authorized the investigation of the Department of Mental Health and Developmental Disabilities' deinstitutionalization initiatives, specifically the case coordinating system, and the number of mentally ill homeless in Illinois. In addition, Illinois (1986 Ill. Laws, S.R. 781) created a Senate Select Committee on the Mentally Ill and Developmentally Disabled to ascertain the number of individuals with mental illness without program supervision, shelter, or medication and recommend the means to improve health care services.

- Indiana (1984 Ind. Laws, P.L. 40) established the state community residential care program and mandated appropriate placement of persons with mental illness in community residential facilities.

Creating a Safety Net. Again, while not exhaustive, the following states provide useful examples of the safety nets that can help the homeless mentally ill.

Illinois (1985 Ill. Laws, P.A. 894-918) acted to keep the temporarily rehospitalized or soon-to-be-discharged individual off the street by providing for the continuation or the immediate restoration of benefits and by requiring interagency agreements to expedite applications for public aid prior to a patient's release.

Maryland (1987 Md. Laws, Chap. 576) now requires residential facilities for individuals with mental illness to implement aftercare plans, including housing, before the individual is released. An individual may not be denied community-based services because he does not have a fixed address.

Virginia (S.J.R. 17) passed legislation in 1986 to ensure that persons with mental illness have an income subsidy if discharged from an inpatient facility or if public benefits are lost.

Other states have created a safety net by coordinating their general mental health services.

- Florida's Community Mental Health Services Act involves a comprehensive and coordinated effort to establish a statewide network of service districts for the treatment of mental illness and substance abuse, overseen by a network of local planning councils (Fla. Stat. § 394.65-394.81 (Supp. 1984)). 1987 legislation requires that local coalitions be established to coordinate the delivery of services to homeless persons in that district (1987 Fla. Laws, Chap. 106).

- Oklahoma (1986 Ok. Laws, Chap. 35) now requires detention or treatment facilities for the mentally ill to provide certain planning and assistance services upon discharge.

- Oregon now requires agreements between community mental health programs and the state hospitals to ensure a continuum of services for patients admitted to and discharged from the state hospital (1981 Or. Laws, Chap. 750).

- Virginia (1986 Va. Acts, Chap. 309) requires that a pre-discharge plan contain information on income subsidies for which the person is eligible, services appropriate for the community treatment plan, and agencies that should be involved in the treatment process.

FUTURE IMPLICATIONS AND DIRECTIONS

The recent rash of television and newspaper reports have helped bring into public focus the brutality and the hopelessness of life on the streets for the individuals who are seriously mentally ill. Yet these same reports have sometimes obscured the larger issues of homelessness. Persons with mental illness are on the streets because the communities simply do not have the community support systems that would help them help themselves. Addressing one homeless individual's immediate need for a meal or a place to sleep does not keep another individual with mental illness from taking to the streets and perpetuating the cycle. Moreover, some feel that temporary programs set up to meet the immediate needs of homeless persons with mental illness often block the process of effective long-range planning.

Without facing squarely the task of providing adequate services for individuals with mental illness living in the community, states can expect continued problems with homelessness. On economic grounds alone, proposals to reinstitutionalize persons with serious mental illness are untenable. But if the policies of the last 20 years are not significantly improved, states can expect to pay dearly for persons with mental illness that end up in the jails, the emergency rooms, and the limited beds in the remaining state mental hospitals.

In order to deal with the population's immediate and often desperate need for food and shelter and to prevent further homelessness, mental health planners, policymakers and providers should focus long-range planning activities in the following areas:

- Improving community mental health and rehabilitation systems so that the basic and specialized needs of persons with mental illness are comprehensively addressed before they become homeless; and

- Improving the emergency and transitional shelter network to provide the homeless individuals who are psychiatrically disabled with appropriate emergency mental health services, as well as linkages to the formal mental health, housing and social service systems.

REFERENCES

1. Stark, Lousia. National Coalition for the Homeless. "The Chronically Mentally Ill Homeless." Transcript of presentation at NCSL Annual Meeting. Seattle, Washington, August 7, 1985.

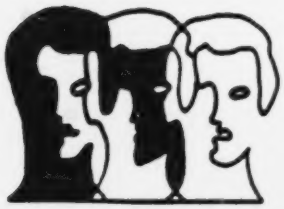
2. American Psychiatric Association. The Homeless Mentally Ill. Richard Lamb, ed. Washington: American Psychiatric Association, 1984.

3. "Report of the Work Group on the Homeless Mentally Ill." Sacramento, California. 1985.

4. Newsletter from California state Assemblyman Bruce Bronzan. "Dramatic Reforms Will Relieve Chaos in California Mental Health System." Sacramento, California. March 18, 1985.

5. Anne Lezak's suggestions largely encapsulate those outlined in "Developing Community Support Systems for the Homeless Who Are Seriously Mentally Ill," authored by Irene Shifren Levine, Anne Lezak and Howard H. Goldman, all of the National Institute of Mental Health.

6. Kozol, Jonathon. Rachel and Her Children: Homeless Families in America. New York: Crown Publishers, Inc., 1988.



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In June 1986, the National Institute of Mental Health (NIMH), U.S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues from 1986 through 1989.

The goal of NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information regarding mental health issues.

During this three-year program, the Mental Health Project will respond to specific issue and format needs of legislators. Under the guidance of the Mental Health Advisory Committee, which is composed of legislators and other persons with mental health experience, Project staff will obtain assistance from expert consultants and state policymakers to provide a variety of services to states, including testimony, special workshops and seminars, and individualized assistance.

Based upon input from the state legislatures, five states will be chosen each year to receive technical assistance on state-specific mental health issues. Along with the programs, the Mental Health Project will develop background materials, audio tapes, and various publications for each issue area. These materials are available free of charge to requesting parties.

The mental health technical assistance program will be offered to the following states during 1987-88:

Illinois	Develop recommendations about community services for mentally ill and developmentally disabled persons
Iowa	Study civil commitment laws to determine whether they should be revised and study the availability of community resources and funding for mental health services
Maine	Review overcrowding at two state inpatient facilities and make recommendations to improve conditions or ensure appropriate community alternatives
Montana	Improve conditions and services at the state hospital to ensure proper care and treatment of patients
Washington	Review overall mental health system, with emphasis on community residential services, involuntary commitment, and funding incentives

The Health and Mental Health Program Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303/623-7800). The acting federal project officer is Vernon James, National Institute of Mental Health (301/443-3606).

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